ARIZONA DEPARTMENT OF HEALTH SERVICES
High Risk Perinatal Program / Newborn Intensive Care Program
Financial Worksheet & Questionnaire

Place Required Label Here
(If label will not fit, place on the back of the form)

1. Infant's Last Name	2. Suffix	3. First Name	4. MI	5. DOB
6. Last Name (Responsible Person)	7. Suffix	8. First Name	9. MI	10. DOB

11. Insured Last Name	12. Suffix	13. First Name	14. MI

15. Infant's Insurance Coverage Type ☐ 3rd Party Private ☐ AHCCCS ☐ KidsCare ☐ IHS non-AHCCCS ☐ None

16. Infant's AHCCCS Status ☐ Eligible ☐ Ineligible ☐ Pending ☐ Refused

17. Infant's AHCCCS #

18. Infant's AHCCCS Eligibility Date

Do include current income of both parents prior to any tax or other deductions. Include mother's income **if she will be returning to work after maternity leave. Include ALL sources of parental income.***

DETERMINATION OF FAMILY LIABILITY

A. Household Size ☐
Include newborn(s), parent(s), siblings & any dependant(s) claimed on latest tax forms.

GROSS ANNUAL HOUSEHOLD INCOME
Father's _____
Mother's _____
Other _____

B. Total **Gross** Household Income*
$ _____

*Include income of both parents, if working. Do not include income of other family members such as grandparents, unless they are assuming financial responsibility for the baby.

Medical expenses are defined as medical, vision and dental expenses, including insurance premiums, incurred from the infant's date of birth and 12 months prior. Do **not** include expenses paid or expected to be paid by any third party insurance payer. Do **not** include current charges for infant's stay in the intensive care unit. **DO** include mother's prenatal care, **mother's hospital charges** and baby's hospital charges before transported (if not enrolled in NICP at that hospital).

Medical, Dentist, and Vision insurance premiums (Deducted from paycheck or direct pay) _____

Doctor, Dentist, and Vision co-pays, deductibles and charges _____

Prescriptions _____

Lab and other medical testing charges _____

Vision Care (glasses/contact lenses) _____

Medical Supplies _____

Surgery Charges _____

Other medical expenses _____

Total Medical Expenses _____

B. Total **Gross** Household Income $ _____

C. Less Total Medical Expenses $ _____

D. Adjusted Gross Income (B minus C) $ _____

E. NICP Family Liability taken from the ADHS Family Liability Table (Use A and D above) $ _____

I hereby request financial assistance for payment of expenses for transport and/or care in the hospital intensive or intermediate care centers in accordance with the policies of the Arizona Department of Health Services (ADHS). I agree to enroll my infant on my third party and/or AHCCCS plan, if eligible, within thirty (30) days from infant's date of birth, and understand that failure to do so will result in denial of NICP financial assistance. I shall assist all providers to obtain 3rd party payments. I have completed the NICP Financial Worksheet & Questionnaire, and will receive a copy from the hospital representative after signing below. I understand that financial assistance is not available for out-of-state hospital, out-of-state physician care, or care through non-contracted hospitals. **I understand that if my Household Income changes during the first 60 days from my infant's date of birth, I may contact the hospital interviewer to complete a revised financial questionnaire. Any revisions must be received by ADHS within 90 days from infant's date of birth.**

_____ _____ _____
Signature of Parent / Guardian / Responsible Person | Relationship to Patient | Date

_____ _____ _____
Signature of Hospital Interviewer | Printed Name of Interviewer | Date

Interviewer Comments _____

6-HRPP-010 (REV. 10/07) *Distribution:* *Original to ADHS* *Yellow to Hospital Billing Office* ***Pink to Family***